Metropolitan SDA Junior Academy

HEALTH REVIEW

Student's Name:____

Grade: ______________ Teacher: ____

Birthdate: ________________ Height: ______________ Weight: _________________

Student's Physician: ____

Address: ____

___________________Phone: ____________________________

Date of last physical exam: ____

Are immunizations up to date: ________yes ________no ______________waived

MEDICAL HISTORY

Has the student had an allergic reaction to any medication? ________yes ______no

If yes, what medication? ____

Has the student had an allergic reaction to anything else, i.e. food, bee stings, plants?

If so, please list ____

What, if any, prescription medication is your child currently taking?__________________

Has your child had any of the following: (if yes, explain below):

Heart problems (murmurs, HPN, etc.)?	No	Yes
Lung problems (asthma, CP, etc.)	No	Yes
Stomach problems (ulcer, nerves, etc.)?	No	Yes
Nervous system problems (epilepsy, etc.)?	No	Yes
Muscular and/or skeletal problems?	No	Yes
Blood disease or bleeding problems?	No	Yes
Behavior problems (ADD/ADHD, etc.)?	No	Yes
Wear glasses or contact lenses?	No	Yes
Any other problems not listed?	No	Yes

Parent's Signature: _______________________________Date: ____________________